



# Department of Defense DIRECTIVE

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Administrative Reissuance Incorporating Change 1, March 17, 1999

ASD(HA)

SUBJECT: Patient Bill of Rights and Responsibilities in the Military Health System  
(MHS)

- References:
- (a) Presidential Advisory Commission on Consumer Protection and Quality in the Healthcare Industry's "Consumer Bill of Rights and Responsibilities," November 1997
  - (b) Presidential Memorandum "The Healthcare Consumer Bill of Rights and Responsibilities," November 20, 1997
  - (c) Presidential Memorandum February 20, 1998 "Federal Agency Compliance with the Patient Bill of Rights"
  - (d) Chapter 55, title 10, United States Code
  - (e) through (i), see enclosure 1

## 1. PURPOSE

This Directive updates policy and assigns responsibilities for MHS implementation of the President's Consumer Bill of Rights and Responsibilities in Healthcare, commonly referred to as the "Patient's Bill of Rights," in accordance with references (a), (b), (c), and (d).

## 2. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense, the Military Departments (including the U.S. Coast Guard when it operates as a Military Service in the Navy), the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Inspector General of the Department of Defense, the Uniformed Services

University of the Health Sciences, the Defense Agencies, and the DoD Field Activities.

### 3. DEFINITIONS

3.1. Military Treatment Facilities (MTFs). Those inpatient and outpatient facilities owned, staffed, and managed by the Military Services.

3.2. National Quality Monitoring Contractor (NQMC). A contract peer review organization that monitors the quality of the Military Health Service's delivered care and services the Office of the Assistant Secretary of Defense for Health Affairs as the external peer reviewer for medical necessity determination appeals.

3.3. Primary Care Manager (PCM). Healthcare providers designated to provide primary and preventive care services and to facilitate appropriate referrals for other services, including specialty services, for TRICARE Prime enrollees. PCMs may include physicians specialized in Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology. Supervised Family Nurse Practitioners, Nurse Midwives, and Physicians Assistants may also be privileged to serve as PCMs.

### 4. POLICY

As set forth below, MHS patients have explicit rights about information disclosure, choice of providers and health plans, access to emergency services, participation in treatment decisions, respect and nondiscrimination, confidentiality of unique health information, and complaints and appeals, as well as specific responsibilities to participate in their own health decisions. This Directive does not expand the scope of benefits or create any entitlement inconsistent with references (d) and (e) or other applicable law or regulation. Additionally, deviation from the guidelines in the Directive does not result in a legal *cause* of action. Finally, failure of a patient to adhere to the "responsibilities" listed in paragraph 4.8. does not, alone, result in a loss of benefits or other adverse action.

4.1. Information Disclosure. MHS patients have the right to receive accurate, easily understood information, and assistance in making informed healthcare decisions about their health plans, providers, and facilities.

4.1.1. MHS beneficiaries shall be provided accurate, understandable, and timely information about the TRICARE program (section 199.17 of 32 CFR,

reference (e)) including details of the covered health benefit, the various health plan options, and applicable cost-sharing arrangements.

4.1.2. Each MTF shall publish a staff provider directory, including information regarding each provider's name, degree, licensure, privileging, board certification and/or re-certification status, and experience. The directory shall be updated at least annually.

4.1.3. Each MTF is required to issue and display in a conspicuous place a quarterly "report card" about facility performance in key areas. The basic elements of the report card include:

4.1.3.1. The waiting times for major services at the MTF, stated as the average number of days patients would expect to wait for an appointment.

4.1.3.2. Results of DoD customer satisfaction surveys about the MTF.

4.1.3.3. The Joint Commission on Accreditation of Healthcare Organization's (JCAHO) survey summary grid score for the MTF and a brief explanation of the meaning of the score.

4.1.3.4. Four specific grid elements from the JCAHO survey about credentials, how competence is assessed, infection control measures, and nursing. This shall be accompanied by short explanations of each grid element.

4.1.4. All plans and/or facilities shall have dedicated representatives available to fully explain the information available and help beneficiaries in their healthcare decisions.

4.1.5. At each direct care facility, Commanders shall provide opportunities for beneficiaries to have direct input to health delivery policy by forming Healthcare *Consortium*.

4.2. Choice of Providers and Plans. MHS beneficiaries have the right to a choice of healthcare providers that is sufficient to ensure access to appropriate, high-quality healthcare.

4.2.1. TRICARE Prime provider networks shall provide access to sufficient numbers and types of providers to ensure that all covered services are accessible within the TRICARE Prime access standards.

4.2.1.1. TRICARE Prime access standards include emergency care 24 hours a day and seven days a week, urgent care within 24 hours, routine primary care within seven days, and specialty care within 30 days.

4.2.1.2. TRICARE Prime access standards are applicable to active duty members under Chapter 55 10 U.S.C. (reference (d)). Priority of care will be given, when necessary, to healthcare evaluations and services related to fitness for duty or explicit readiness requirements.

4.2.1.3. MHS beneficiaries entitled under law to the Civilian Health and Medical Program of the Uniformed Services have a right to choose TRICARE Standard, which permits access to all authorized providers within guidelines of the TRICARE Program.

4.2.2. TRICARE Prime enrollees have the freedom to choose any available PCM within the responsible MTF. If no PCM is available within the MTF, or with the approval of the MTF commander, enrollees have the right to choose a civilian network PCM. In the case of active duty Service members, choice of PCMs is subject to readiness requirements of the Military Service.

4.2.3. The MHS shall promote the availability of providers who have special training in women's health issues to serve as PCMs for female Prime enrollees. To the extent available, female enrollees should be offered the option to choose a PCM who has advanced training in women's health issues.

4.2.4. Prime enrollees with complex or serious medical conditions who require frequent specialty care shall be authorized direct access to a qualified specialist of their choice within the MTF (or, if authorized, in the civilian provider network). Authorization shall be for an appropriate number of visits under an approved treatment plan.

4.2.5. Beneficiaries undergoing a course of treatment for a chronic or disabling condition or who are in the second or third trimester of a pregnancy at the time there is an *involuntary* change in coverage of the specialty services being provided, shall, to the extent possible, be able to continue seeing their current specialty provider for up to 90 days (or through completion of postpartum care) to preserve continuity of care and allow for transition of care.

4.2.5.1. For purposes of this policy, an involuntary change includes an involuntary loss of eligibility for the MHS, an involuntary loss of other health

insurance coincident with the initiation or continuation of MHS eligibility, termination of the provider by the TRICARE Prime contractor for other than cause, or a change in the applicable TRICARE support contractor.

4.2.5.2. In the case of an involuntary loss of eligibility for the MHS, the continued transitional access to healthcare shall be through the Military Departments' Transition Assistance Programs, the continued Health Benefits Program of 10 U.S.C. section 1078a (reference (d)), and their Secretarial Designee Programs as appropriate.

4.2.5.3. In the case of an involuntary loss of other health insurance coverage coincident with the continuation or initiation of MHS eligibility, continued transitional coverage of the specialty care involved shall be through TRICARE, in accordance with Section 199.17 of 32 CFR (reference (e)).

4.2.5.4. In the case of a termination of the provider involved (for other than quality concerns) or a change in the applicable TRICARE support contractor affecting a TRICARE Prime enrollee, continued transitional coverage of the specialty care involved shall be through command referral (if the beneficiary remains enrolled in TRICARE Prime) with applicable TRICARE Prime cost-sharing amounts applied.

4.3. Access to Emergency Services. MHS beneficiaries have the right to access emergency healthcare services when and where the need arises. Emergency services are covered in circumstances where acute symptoms are of sufficient severity that a "prudent layperson" could reasonably expect the absence of medical attention would result in serious health risks.

4.3.1. There is no requirement for preauthorization for emergency services.

4.3.2. Providers and/or facilities are subject to payment limits either because of network agreements or regulations on balance billing.

4.3.3. Beneficiaries shall be provided information on the location, availability and appropriate use of emergency services, cost sharing, provisions for civilian emergency services, and availability of care outside of an emergency department.

4.3.4. Healthcare advisory lines will be staffed by nursing personnel 24 hours a day to help beneficiaries decide if emergent care is needed. Access to a PCM will be available after hours if deemed necessary by the health advisor.

4.4. Participation in Treatment Decisions. MHS beneficiaries have the right and responsibility to fully participate in all decisions related to their healthcare, subject to readiness requirements for active duty Service members.

4.4.1. To the extent practical, MTF and TRICARE Prime network healthcare professionals shall provide patients with easily understood information and the opportunity to decide among treatment options consistent with the informed consent process. Specifically, providers should:

4.4.1.1. Discuss all treatment options including the option of no treatment at all with a patient in a culturally competent manner.

4.4.1.2. Ensure that patients with disabilities have effective communications with members of the health system in making such decisions.

4.4.1.3. Discuss all current treatments a patient may be undergoing, including those alternative treatments that are self-administered.

4.4.1.4. Discuss all risks, benefits, and consequences to treatment or non-treatment.

4.4.1.5. Give competent patients the opportunity to refuse treatment and to express preferences about future treatment.

4.4.2. Providers should discuss the use of advance directives—both living wills and durable powers of attorney—with patients and their designated representative, and should abide by all decisions made by their patients and/or their designated representatives. A provider who disagrees with a patient's wishes as a matter of conscience should arrange for transfer of care to another qualified provider willing to proceed according to the patient's wishes within the limits of the law and medical ethics. Signed advance directives shall become part of the medical record.

4.4.3. MTF and TRICARE network providers and facilities shall disclose to patients financial arrangements, contractual restrictions, ownership of or interest in healthcare facilities, matters of conscience, or other factors that could influence medical advice or treatment decisions. TRICARE network provider contracts shall not contain any so-called "gag clauses" or other contractual mechanisms that restrict the healthcare provider's ability to communicate with and advise patients about medically necessary treatment options.

4.4.4. The MHS shall not penalize or seek retribution against healthcare professionals or other health workers for advocating on behalf of their patients.

4.4.5. For active duty Service members, rights under subsection 4.4., above, are subject to responsibilities of the member to comply with Service requirements for military readiness and the Uniform Code of Military Justice (reference (f)).

4.5. Respect and Nondiscrimination. MHS beneficiaries have the right to considerate, respectful care from all members of the MHS at all times and under all circumstances in an environment of mutual respect and free from discrimination. Subject to eligibility and other requirements of law and DoD regulation under Chapter 55 of 10 U.S.C. and 32 CFR 199 references (d) and (e) and reference (f), the MHS does not discriminate in the delivery of healthcare services or in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, genetic information, sexual orientation, or source of payment.

4.6. Confidentiality of Health Information. MHS beneficiaries have the right to communicate with healthcare providers in confidence, to have the confidentiality of their individually identifiable healthcare information protected, and to review and copy their own medical records and request amendments to their records, subject to limited exceptions for which there is a clear legal basis.

4.6.1. The maintenance and management of health information by the MHS is governed by the Privacy Act and the DoD Privacy Program (references (g) and (h)). Under these authorities:

4.6.1.1. All individual identifiable medical information is protected and its use is generally restricted for healthcare purposes only, including the provision of healthcare, payment of services, peer review, health promotion, and quality assurance.

4.6.1.2. Only upon a clear legal basis is nonconsensual disclosure of information allowed. Such reasons may include investigations into healthcare fraud, public health reporting, medical or healthcare research consistent with rules for the protection of human subjects in research under Part 219 of 32 CFR (reference (i)).

4.6.2. Also consistent with the Privacy Act and the DoD Privacy Provision, there is a clear legal basis for nonconsensual disclosure of information related to military personnel fitness for duty or other readiness related requirements.

4.7. Complaints and Appeals. MHS beneficiaries have the right to a fair and efficient process for resolving differences with their healthcare providers, MTF, or TRICARE contractor, including a rigorous system of internal review and an independent system of external review.

4.7.1. When healthcare services are denied by an MTF (which will neither provide nor authorize TRICARE payment for) or a TRICARE contractor (which will not authorize TRICARE payment for) based on a determination that the services are not medically necessary (including experimental or investigational), the beneficiary has the right to internal and external appeals.

4.7.2. Internal appeals subject to paragraph 4.7.1., above, shall follow reconsideration procedures consistent with 32 CFR 199.15 (f) through (h) (reference (e)) for the TRICARE Quality and Utilization Review Peer Review Organization Program. This shall include written notification of the decision, the reasons for the decision, and appeal procedures; timely resolution, including special emergency time standards, use of credentialed providers not involved in the initial decision; and written notification of the reconsideration decision, the reasons for it, and the external appeal procedures.

4.7.3. External appeals subject to paragraph 4.7.1., above, shall follow the procedures established pursuant to Section 199.15 (f) through (i) of reference (e), including reconsideration by the independent National Quality Monitoring Contractor (NQMC) and appeals and hearing before the TRICARE Management Activity. NQMC procedures shall require determinations by appropriately credentialed specialty providers not involved in the initial decision, timely resolution, and emergency time frames consistent with Medicare's appeal process.

4.7.4. Beneficiaries with grievances about specific treatment or coverage decisions other than those covered by paragraph 4.7.1., above, shall have an opportunity to seek resolution through the MTF or TRICARE contractor involved through procedures widely disseminated to beneficiaries.

4.7.5. Subsection 4.7., above, does not apply to beneficiary disagreements with eligibility requirements, coverage exclusions, or other matters established by law or regulation (including Chapter 55 of 10 U.S.C. (reference (d) and reference (e)) or MTF determinations of space available care (including the availability of services, pharmaceuticals, equipment, or other items from MTFs).



4.8. Beneficiary Responsibilities. In the MHS beneficiaries are expected and encouraged to assume reasonable responsibility for their health. This increases the likelihood of achieving the best outcomes and supports quality improvement and a cost-conscious environment. Such responsibilities include:

4.8.1. Taking responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet, and avoiding knowingly spreading disease.

4.8.2. Becoming involved in specific healthcare decisions, working collaboratively with healthcare providers in developing and carrying out agreed-upon treatment plan and disclosing relevant information and clearly communicating wants and needs.

4.8.3. Recognizing the reality of risks and limits of the science of medical care and the human fallibility of the healthcare professional and being aware of a healthcare provider's obligation to be reasonably efficient and equitable in providing care to other patients.

4.8.4. Becoming knowledgeable about MHS and TRICARE coverage, options, and rules and abiding by applicable procedures.

4.8.5. Showing respect for other patients and health workers and making a good-faith effort to meet financial obligations.

4.8.6. Reporting wrongdoing and fraud to appropriate authorities.

## 5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall exercise oversight to ensure compliance with this Directive and issue additional DoD Instructions to implement the policy in this Directive as necessary.

5.2. *The Secretaries of the Military Departments shall implement this Directive and any DoD supplementing Instructions issued by ASD(HA).*

6. EFFECTIVE DATE

This Directive is effective 1 August, 1998.

A handwritten signature in black ink, reading "William S. Cohen". The signature is stylized, with a large, circular flourish at the end of the last name.

William S. Cohen  
Secretary of Defense

Enclosures - 1

E1. References, continued

E1. ENCLOSURE 1

REFERENCES, continued

- (e) Title 32, Code of Federal Regulations, Part 199, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)"
- (f) Chapter 47 of title 10, United States Code "Uniformed Code of Military Justice"
- (g) Section 552a of title 5, United States Code, "Privacy Act"
- (h) Title 32, Code of Federal Regulations, Part 310, "DoD Privacy Program"
- (i) Title 32, Code of Federal Regulations, Part 219, "Protection of Human Subjects"